35B. MONTHLY AMOUNT		35C. BEGINNING DATE	35D. DATE OF INTENTION TO APPLY	35E. SOURCE OF BENEFITS
VETERAN	$			
SPOUSE	$			

VETERAN'S AND DEPENDENTS' MONTHLY INCOME

NOTE: For each source report gross monthly amount, including deductions, for each family member.

ITEM NO.	SOURCE OF MONTHLY INCOME	AMOUNTS *(If none, write "NONE" or "0")*				
		VETERAN	SPOUSE	NAME OF CHILD/REN		
36A	SOCIAL SECURITY	$	$	$	$	$
36B	U.S. CIVIL SERVICE					
36C	U.S. RAILROAD RETIREMENT					
36D	MILITARY RETIREMENT					
36E	BLACK LUNG BENEFIT					
36F	SUPPLEMENTAL SECURITY/PUBLIC ASSIST.					
36G	ALL OTHER MONTHLY INCOME *(Specify Source)*					

VETERAN'S AND DEPENDENTS' OTHER INCOME *(If none, write "NONE" or "0")*

NOTE: Please provide the amount of annual income or one-time nonrecurring income (specify source) for the 12 month period preceding the date the claim is filed with the Department of Veterans Affairs.

37A	TOTAL WAGES					
37B	TOTAL INTEREST AND DIVIDENDS					
37C	ALL OTHER INCOME *(Specify Source)*					

NOTE: Please provide the amount of expected annual income or one-time nonrecurring income (specify source) for the 12 month period following the date the claim is filed with the Department of Veterans Affairs.

38A	TOTAL WAGES					
38B	TOTAL INTEREST AND DIVIDENDS					
38C	ALL OTHER INCOME *(Specify Source)*					

39A. GROSS AMOUNT OF FINAL PAY RECEIVED	40. REMARKS *(Identify your statements by their applicable item number. If additional space is required, attach separate sheet and identify your statements by their item numbers)*
39B. DATE FINAL PAY WAS RECEIVED	

NOTE: Items 41A through 41G should be completed only if you are applying for nonservice-connected pension.

INFORMATION CONCERNING MEDICAL, LEGAL OR OTHER EXPENSES

NOTE: Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid for yourself or relatives you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Show the Medicare deduction in line 1.

41A. AMOUNT PAID BY YOU	41B. DATE PAID	41C. PURPOSE *(Doctor's fees, hospital charges, Attorney fees, etc.)*	41D. PAID TO *(Name of doctor, hospital, pharmacy, Attorney, etc.)*	41E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID
		Medicare (Part B)	SOCIAL SECURITY ADMINISTRATION	

41F. ARE YOU NOW A PATIENT IN A NURSING HOME?	41G. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?
☐ YES ☐ NO *(If "YES," please complete Item 41G)*	☐ YES ☐ NO *(If "YES," give the name and address of the nursing home in Item 40, "Remarks")*

NOTE: Filing of this application constitutes a waiver of military retired pay in the amount of any VA compensation to which you may be entitled. See instructions for Items 14A thru 14D inclusive, Retired Pay.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I CERTIFY THAT the foregoing statements are true and complete to the best of my knowledge and belief. I CONSENT THAT any physician, surgeon, dentist, or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to the Department of Veterans Affairs any information about myself, and I waive any privilege which renders such information confidential. DO YOU WANT TO HAVE MEDICAL AND OTHER INFORMATION ABOUT YOU INCLUDED IN THE "PERSIAN GULF WAR VETERANS HEALTH REGISTRY?" (See "GENERAL INSTRUCTIONS," paragraph K.) ☐ YES ☐ NO

42. SIGNATURE OF CLAIMANT SIGN HERE ▶	43. DATE SIGNED

WITNESSES TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK

NOTE: A signature by mark must be witnessed by two persons to whom the person making the statement is personally known. The witnesses must sign their names in Items 44A and 45A and type or print their names and addresses in Items 44B and 45B.

44A. SIGNATURE OF WITNESS	45A. SIGNATURE OF WITNESS
44B. NAME AND ADDRESS OF WITNESS *(Type or print)*	45B. NAME AND ADDRESS OF WITNESS *(Type or print)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.